

# Medical Record Release Form

Patient Name: \_\_\_\_\_

Date of birth:        /        /

Sex:    ☐ Male    ☐ Female

## Patient/Guardian Authorization

**You may use or disclose the following health care information:**

☐ All my health information including, but not limited to, AIDS/HIV and other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless, specifically excepted: \_\_\_\_\_

☐ Other \_\_\_\_\_

**You may disclose this health information to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Do you want us to ☐ fax or ☐ mail your child's medical record?**

This authorization is valid for six(6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian)